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	445107	A. BUILDING _____ B. WING _____	02/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NHC HEALTHCARE, FT SANDERS	2120 HIGHLAND AVE KNOXVILLE, TN 37916

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS During an annual recertification survey and complaint investigation numbers TN28888 and TN28968, completed on February 8, 2012, no deficiencies were cited related to complaint TN28968 under 42 CFR Part 482.13 Requirements for Long Term Care.	F 000		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: . Based on medical record review, observation, and interview, the facility failed to provide personal hygiene in a timely manner for one resident (#17) of twenty-five resident reviewed. The findings included: Resident #17 was admitted to the facility on July 5, 2010, with diagnoses including Severe Kyphosis, Hypertension, Coronary Artery Disease, and Peripheral Vascular Disease. Medical record review of the Minimum Data Set (MDS) dated November 22, 2011, revealed the resident required extensive physical assistance of one person for toilet use and cleansing self after bladder/bowel elimination.	F 312	F 312 1. CNA responded to call light of Resident #17 at aprox. 9:55 am. CNA had been in the room 2 separate times that morning for breakfast tray delivery and pick-up. ADL assistance was provided in response to call light and included, shower, personal hygiene, grooming and dressing assistance. 2. A review was performed by floor supervisors and no other Resident's were affected by deficient practice. 3. In-Servicing completed with all nursing staff regarding timeliness of answering call lights and ADL assistance. 4. Floor Supervisors to monitor timeliness of answering call lights by staff.	02/06/12 02/06/12 02/15/12 02/15/12 and On-Going

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Douglas S. Ford — TITLE: NHA — (X6) DATE: 2/16/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 312	Continued From page 1 Observation of resident #17 on February 6, 2012, at 9:35 a.m., revealed the resident lying in bed; interview with the resident at time of observation revealed the resident stated had called for assistance to be cleaned up. Continued interview revealed the resident had called for assistance three times and no staff had come to the resident's aide. Further interview revealed the resident was laying in bowel movement; resident stated had been asking for assistance since between 7:30 a.m. and 8:00 a.m. The surveyor encouraged the resident to call for assistance again, the resident was hesitant due to "afraid of making the staff upset". The resident called for assistance at 9:35 a.m., the nurses' station answered call and informed resident staff would be right there. Staff entered to provide assistance at 9:55 a.m. (20 minutes later). Interview with Licensed Practical Nurse #5 (LPN) on February 7, 2012, at 2:30 p.m., at the nurses' station, verified would expect some staff person to help/assist the resident within 5-10 minutes of a request. Interview with Charge Nurse #1 (CN) on February 7, 2012, at 2:35 p.m., at the nurses' station, verified would expect a staff person to help/assist a resident within 5-10 minutes. Interview with the House Supervisor on February 7, 2012, at 3:25 p.m., at the nurses' station, confirmed expects the staff to help any resident who asks for assistance within 5-10 minutes. .	F 312	See Page 1 of 13	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431	See Page 3 of 13	

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F 431	Continued From page 2 The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to properly separate topical and oral	F 431	F 431 1. Medication Carts inspected with removal of expired drug with proper disposal. Topical medications separated from p.o medications from the 2 of 6 medication carts. 2. Review of all remaining medication carts inspected with no other deficiencies found. 3. In-Servicing completed on daily monitoring by 11-7 staff for proper storage of medications and monitoring of expired medications. 4. Continue monthly medication cart inspections by licensed pharmacy staff.	02/06/12 02/06/12 02/15/12 02/15/12 and On-Going

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medications for two of six medication carts and failed to ensure medications were not available for use beyond the expiration date on one of six medication carts.

The findings included:

Observation of the third floor long hall medication cart on February 7, 2012, at 1:34 p.m., revealed one bottle of Chloraseptic spray (throat analgesic) with no prescription label and an expiration date of July 2011.

Interview with Licensed Practical Nurse (LPN) #3 on February 7, 2012, at 1:34 p.m., at the third floor nurses station, confirmed the medication was available for use beyond the expiration date.

Observation of the second floor short hall medication cart on February 7, 2012, at 1:59 p.m., revealed Nystatin Cream (antifungal) and Paxil (antidepressant) 40 milligram tablets were located within the same compartment in the medication cart.

Interview with LPN #2 on February 7, 2012, at 1:59 p.m., at the second floor nurses station, confirmed topical ointments and oral medications were not to be stored in the same medication compartment.

Observation of the first floor short hall medication cart on February 7, 2012, at 2:20 p.m., revealed Saline Nasal Spray and two tubes of Bactroban (antibacterial) ointment were located within the same compartment in the medication cart.

Interview with LPN #4 on February 7, 2012, at

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F 431	Continued From page 4 2:20 p.m., at the first floor nurses station, confirmed internal and external medications were not to be stored in the same medication compartment.	F 431	See Page 3 of 13	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens	F 441	F 441 1. Staff educated on proper Infection Control Techniques while performing duties on affected Residents. 2. Resident's reviewed with no other Residents found to be affected. 3. In-Service completed on proper hand washing and proper cleaning of medication vial tops prior to use. 4. Random rounds to monitor proper pericare, handwashing technique, vial medication administration technique, and wound care technique. Continue monthly Infection Control meetings to identify trends as well as continued focus on Infection Control.	02/06/12 02/06/12 02/15/12 02/15/12 and On-Going

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F 441	Continued From page 5 Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, facility policy review, and interview, the facility failed to maintain infection control for the treatment cart during dressing change for one resident (#1); failed to ensure staff washed hands after providing direct resident care for one resident (#17); failed to ensure hand washing during a dressing change for one resident (#25) of twenty-five residents reviewed; and failed to wash the hands during medication administration and to clean injection ports of insulin bottles prior to withdrawing insulin for three of three insulin administrations observed. The findings included: Resident #1 was admitted to the facility on March 6, 2008, with diagnoses including Atrial Fibrillation, Coronary Artery Disease, Hypertension, and Esophageal Reflux. Record review revealed the resident started receiving Hospice Care on November 18, 2011. Observation on February 6, 2012, at 3:15 p.m., revealed a Hospice Nurse was doing a dressing change. Continued observation revealed the Hospice Nurse took the treatment cart into the resident's room, and stationed the cart next to the resident's bed.	F 441	See Page 5 of 13	

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F 441	Continued From page 6 Interview with the Hospice Nurse on February 6, 2012, at 3:30 p.m., in the hallway, confirmed always took the treatment cart into the resident's room. Observation of the treatment cart on February 7, 2012, at 8:10 a.m., with LPN #5 revealed the cart contained individual containers of normal saline, different sizes of gauze, disinfectant wipes, hand sanitizer, tape, alcohol pads, individual medications, moisturizing creams, zinc creams, foam gauze pads. Interview with LPN #5 at the time of observation revealed the treatment cart was to stay in hallway due to infection control. Interview with the Assistant Director of Nursing on February 7, 2012, at 12:05 p.m., in the hallway, confirmed the treatment cart was not to be taken into resident's rooms due to infection control. Resident #17 was admitted to the facility on July 5, 2010, with diagnoses including Severe Kyphosis, Hypertension, Coronary Artery Disease, and Peripheral Vascular Disease. Observation on February 6, 2012, at 10:00 a.m., in the resident's room, revealed Certified Nursing Assistant #1 (CNA) was wearing gloves providing incontinence care of a bowel movement. Continued observation revealed after the CNA provided the care the CNA removed the soiled brief and pad and placed in a plastic bag. Continued observation revealed the CNA did not remove the soiled gloves/wash the hands; placed a clean gown on the resident, pulled the privacy curtain, retrieved the shower chair stationed in the foyer of the room, moved the over bed table, moved the plastic container of the disposable	F 441	See Page 5 of 13	

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wipes, assisted the resident to the shower chair, placed a clean blanket around the resident, using the same gloves to provide the incontinence care.

Review of the facility's policy Handwashing dated October 1, 2008, revealed " ...wash hands before and after contact with each patient ..."

Interview with the Director of Nursing on February 8, 2012, at 8:10 a.m., in the hallway, confirmed gloves are to be removed and hands washed after providing incontinence care.

Resident #25 was re-admitted to the facility on November 7, 2011, with diagnoses including Status Post Flap Procedure, Diabetes Mellitus, and Paraplegia.

Medical record review of the Weekly Wound Assessment Record updated January 31, 2012, revealed the resident had a surgical wound to the left proximal (upper buttocks/lower back area) buttocks measuring 2.7 centimeters (cm) by 12.6 cm with a depth of 2.3 cm, and undermining of 8.9 cm; a surgical wound to the right ischial (lower buttocks area) measuring 1.4 cm by 2.1 cm with a depth of 0.3 cm; and a surgical wound to the left ischial measuring 1.0 cm by 0.6 cm, with a depth of 0.3 cm.

Observation of a dressing change on February 7, 2012, from 9:45 a.m., until 10:20 a.m., in the resident's room, revealed Licensed Practical Nurse #5, without washing or sanitizing the hands, entered the resident's room with supplies to change three dressings on the resident's buttocks. Further observation revealed the LPN, without washing or sanitizing the hands, prepared

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F 441	Continued From page 8 an over bed table with the supplies for the dressing changes. Further observation revealed, without washing or sanitizing the hands, the LPN donned gloves, removed the old dressings from the left proximal buttocks and the left ischial, pulled soiled gauze packing from the pocket of the left proximal buttocks wound, and without washing or sanitizing the hands, changed gloves, cleaned the wound by irrigating it with a 60 milliliter syringe of normal saline, packed the wound pocket with wet gauze, opened two packages of dry gauze, covered the wound with the dry gauze, removed the soiled gloves and, with ungloved hands, secured the dressing with tape. Further observation revealed, without washing or sanitizing the hands, the LPN cleaned the over bed table, prepared supplies for the next dressing, donned clean gloves, and cleaned the left ischial wound. Further observation revealed, without washing or sanitizing the hands, the LPN changed gloves, covered the left ischial wound with wet gauze, then dry gauze, and secured with tape. Further observation revealed the LPN removed the soiled gloves, without washing or sanitizing the hands, donned clean gloves, changed the resident's draw sheet, rolled the resident to the left side, moved the over bed table to the opposite side of the bed, opened new supplies, and removed the gloves. Further observation revealed the LPN, without washing or sanitizing the hands, prepared the supplies for the next dressing change, donned clean gloves, removed old linen from the resident's bed, removed the dressing from the right ischial wound, and removed the soiled gloves. Further observation revealed, without washing or sanitizing the hands, the LPN donned clean gloves, cleaned the wound, covered the wound	F 441	See Page 5 of 13	

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F 441	Continued From page 9 with wet gauze, then covered the wound with dry gauze, removed the soiled gloves, and, with ungloved hands, secured the dressing with tape. Further observation revealed the LPN, without washing or sanitizing the hands, donned clean gloves, positioned the resident in bed, and gathered up trash from the room. Observation revealed the LPN washed the hands before leaving the resident's room. Review of the facility's policy, Dressing-Clean Technique, revised June, 1997, revealed, "...Wash hands before and after procedure and wear gloves..." Review of the facility's policy, Handwashing, revised October 1, 2008, revealed, "...Wash hands before and after contact with each patient...and before and after removal of gloves..." Interview with LPN #5 on February 7, 2012, at 10:23 a.m., outside the resident's room, confirmed the LPN did not wash or sanitize the hands before beginning the dressing change, did not wash or sanitize the hands after removing the soiled dressings, before applying clean dressings, and did not wash or sanitize the hands between dressing changes for multiple, separate wounds. Interview with the Director of Nursing (DON) on February 7, 2012, at 10:45 a.m., in the DON'S office, confirmed nursing staff were trained to wash or sanitize the hands prior to beginning a dressing change, between removing soiled dressings and applying clean dressings, and in between dressing changes for multiple separate wounds.	F 441	See Page 5 of 13	

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F 441	Continued From page 10 Observation of Licensed Practical Nurse (LPN) #1 on February 6, 2012, at 4:30 p.m., on the first floor, revealed the LPN donned gloves before checking a finger stick blood sugar (FSBS), completed the FSBS, removed the gloves, and without washing the hands, obtained an insulin syringe. Continued observation revealed the LPN obtained the insulin bottle previously opened, and did not clean the injection port prior to withdrawing the insulin. Interview with LPN #1 on February 6, 2012, at 4:45 p.m., on the first floor long hall, confirmed the hands were not washed before drawing up insulin for administration and the insulin bottle injection port was not cleaned prior to withdrawing insulin. Review of the facility's Handwashing policy dated October 1, 2008, revealed, "...wash hands before and after contact with each patient...and before and after removal of gloves..." Observation of LPN #2 on February 7, 2012, at 7:37 a.m., at the second floor nurses' station, revealed LPN #2 drew up insulin in a syringe for administration for one resident. Further observation revealed the insulin bottle had been setting in the medication cart, previously opened, and the injection port was not cleaned prior to withdrawing insulin. Further observation of LPN #2 on February 7, 2012, at 7:44 a.m. at the second floor nurses' station, revealed LPN #2 drew up insulin in a syringe for administration to a second resident. Further observation revealed the insulin bottle	F 441	See Page 5 of 13	

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F 441	Continued From page 11 had been setting in the medication cart, previously opened, and the injection port was not cleaned prior to withdrawing the insulin. Interview with LPN #2 on February 7, 2012, at 7:44 a.m., at the second floor short hall, confirmed the insulin bottles were not cleaned prior to withdrawing insulin. Interview with the Director of Nursing (DON) on February 7, 2012, at 10:45 a.m., in the DON office, confirmed the "expectation is that insulin vials will be cleaned by alcohol if already opened."	F 441	See Page 5 of 13	
F 514 SS=D	C/O #28888 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to assure the medical record reflected administration of a house supplement	F 514	F 514 1. House Supplement added to MAR Flow sheet of affected Resident. In-house Registered Dietician notified with no negative outcomes noted. 2. Residents reviewed with no other Residents found to be affected. 3. Floor Supervisors to check MAR monthly for accuracy. 4. Random MAR checks by floor supervisors as well as continued nightly 24 hour chart checks by licensed staff.	02/06/12 02/06/12 02/15/12 02/15/12 and On-Going

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F 514	Continued From page 12 for one resident (#2) of twenty-five residents reviewed. The findings included: Resident #2 was readmitted to the facility on September 12, 2011, with diagnoses including Decubitus Ulcer, Chronic Kidney Disease, Dementia, and Hypertension. Medical record review of a Physician's Telephone Order dated November 18, 2011, revealed "...house supplement TID (three times a day) with meals..." Interview and medical record review with Resident Care Coordinator #1, on February 7, 2012, at 9:00 a.m., revealed the December, January and February Medication Administration records (MAR) did not document the administration of the house supplement. Interview with the Director of Nursing on February 8, 2012, at 9:05 a.m., in the Director's office confirmed the MAR's did not document administration of the house supplement for December, January, and February.	F 514	See Page 12 of 13	